

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 28, 2004
9:32 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Public Comment

MS. McILRATH: I just wanted a couple of words about the SGR. We are very grateful to the Commission for being against the thing and having it removed. It hasn't happened yet. So long as it exists, it seems like in the discussions that you have on different issues that affect physicians that one should always keep in mind what will be the impact so long as you have the SGR.

So in that respect, I would like to endorse what Dr. Wolter said about looking at the impact of the growth of the drugs on the SGR.

Just to give you a little more flavor for how fast that is increasing, it was 3.7 percent of the pool in the base year. It's 12 percent now. It's expected to go to 29 percent in 10 years.

So physician services may be driving the increases right now. They certainly are growing at a small, minuscule part of the rate at which the drugs are growing. And so you get to a point where not only are they a bigger share of the pool, but because they are a bigger share of the pool and because the penalty is not applied to the drugs, then the part of the services for which the penalty is applied is smaller and smaller and therefore the penalty has to be bigger and bigger. And there's more and more likelihood that you will exceed the target because the drugs are growing so rapidly.

Another point, just to look at when you're looking at expenditure shift and when you're looking at what's happening with imaging, there was a comment about looking to see did growth in physician services have an impact on quality. I would say you should probably also be looking at did it have an impact on spending in other sectors.

We know that there are 95 codes that now have a practice expense in a physician's office that in the beginning of the practice expense, the resource-based practice expenses, they didn't even have an office-based practice expense. So that alone, there is a big shift over there and there's no way that there's no adjustment whatsoever for any of that.

And then just to conclude, on the electronic records there was a discussion and one of the physicians said one of the things that was good about that for the practice was that it sent out reminder notices and people came in more frequently. I would say that could have an impact on the SGR, as well. Obviously, in some cases there may be some trade-off. In the chronic care Medicare demonstrations we talked about it. But it's frequently a trade-off on the hospital side. You do more on the physician side to get a savings on the hospital side.

So it would be helpful, I think, if the Commission, when it's talking about doing some of the things that everybody wants

to do, would talk about the restraint that the SGR imposes on doing those things.

DR. GUCCIONE: Andrew Guccione of the American Physical Therapy Association. First of all, once again I want to thank commissioners for considering the issue that was put before you today, and we certainly appreciate the conversation and the discussion.

We also appreciate that regardless of whether individual commissioners believe the referral requirement should be retained or not, there does seem to be widespread agreement that the physician referral requirement does not serve the purpose for which it was intended, which is as a utilization control. And that recognition, we think, is quite valuable.

We also certainly appreciate staff's very cautious presentation of counterarguments and the conditional use of may and could is very heartening. Obviously the association presented the strongest evidence in support of the arguments we put forward, and we believe the strongest evidence that is out there to be used. Clearly, the counterarguments are speculative.

I think that we would certainly look forward at some time to working with commissioners and staff to answer some of the questions about evidence-based practice which have arisen about physical therapy in particular. We are delighted that, in response to our work with the OIG and CMS over the last several years, we have actually an electronic patient record which will be entering the marketplace this spring with an outcomes instrument which will lead to a national outcomes database, as well as we also have available to physical therapist members a repository of now over 1,600 articles summarizing the peer reviewed literature on treatment effectiveness with the calculation of effect sizes where such calculations were appropriate.

So we're taking our commitment to avoid medically unnecessary services and to eliminate the abuses that we see in what is charged for as PT. We take that very, very seriously.

However, all that said, and given the speculative nature, I think we would have hoped and we still may hope that the commissioners might find themselves exactly where the Senate did when it actually passed its version of the bill that finally got this issue to MedPAC, which was that to truly answer these questions one needs to study them directly.

The Senate version of this bill actually had included a demonstration project, a limited demonstration project in five states. We were very enthusiastic about that possibility. Should that possibility still go forward, we would be delighted to finally have the answers to these questions, given the recognition that the physician referral requirement does not have the effect that it has been proposed to have.

Thank you.

MR. HOGAN: I'm Mike Hogan with the Society of Thoracic Surgeons. I have a number of pieces of information that you had asked for in your deliberations over the adequacy of practice

expense payments to cardiothoracic surgeons. To be merciful, I will submit them to you all in writing.

But there's one piece of information or a major point that I think was absent in your deliberations and that is this. Medicare is paying for the cost of these clinical assistants that cardiothoracic surgeons bring to the hospital to help them in surgery every day. These costs are being paid by Medicare but they're just not going to cardiothoracic surgeons. Because of the way they calculated it, these costs are being leaked to the E&M codes in the form of two cents for every E&M visit billed by every physician in the Medicare program.

These costs are in there. So there's an easy, equitable, budget neutral solution and that is just to recapture these costs out of the E&M pools and back into the cardiothoracic practice expense.

There were a couple of things that were inaccurate in the slides that you saw and I just wanted to correct in two places on slides five and six. It says that the work RVUs for these positions take into account or pay them for the costs of these clinical assistants. That's not true. The RVUs are specifically physician time and physician time only.

The rest I will submit to you in writing.

Thank you.

MS. STEIN-LLOYD: My name is Leslie Stein-Lloyd and I represent the American Occupational Therapy Association. We appreciate the opportunity to be able to address you today. We particularly appreciate the outreach that your staff has had in contacting us to get our opinions, the occupational therapists opinions, on this important issue of therapist access to patients and the relationship with physician referrals.

It struck us today that, first of all, we want to note that we have brought some copies of our letter that have our viewpoints on this issue because we strongly feel that any referral changes that may be contemplated now or in the future for physical therapy should be applied to all three therapist disciplines, as well.

It struck us when we were listening to what you were talking about on accessing appropriate care that the Institute of Medicine has recently come out with a compelling study called the Health Professions Education: A Bridge to Quality. It deliberates many aspects of how to attain quality care through education. One of the major findings is that collaboration among clinicians is essential to assuring patient safety quality of care.

AOTA strongly believes that individuals have the right to direct their own health care and that the right of patients to direct their own health care can be greatly enhanced by the collaboration approach to rehabilitation. That does include the collaboration between physicians and therapists like occupational therapists.

We also hope that if you continue to consider this issue in the future that you will include in your discussions equal access

to all three therapies.

Thank you.

MR. HACKBARTH: Thank you. We will reconvene at 9:00 a.m.

[Whereupon, at 5:35 p.m., the meeting was adjourned, to reconvene at 9:00 a.m. on Friday, October 29, 2004.]